Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004811	A. BUILDING _____ B. WING _____	10/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL INDIANA AMG SPECIALTY HOSPITAL LLC	2401 W UNIVERSITY AVE 8TH FL MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN 00110200 Substantiated: No deficiencies cited Date: 10-29-2012 Facility Number: 004811 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor Central Indiana AMG Specialty Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services, 410 IAC 15-1.6-7, Respiratory therapy and 410 IAC 15-1.5-10, Utilization review and discharge planning services, Indiana Hospital Licensure Rules. QA: claughlin 12/28/12	S 000		

Indiana State Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE